WORKERS COMPENSATION INSTRUCTIONS

Supervisors are to report all work-related incidents/accidents to the Human Resources within 24 hours of the accident or injury.

EMERGENCIES

Seek medical attention IMMEDIATELY in a life-threatening situation. Complete the required forms once medical professionals attend to the injured worker.

NON-EMERGENCIES

FORMS

1. **SUPERVISOR INTAKE FORM –** completed by the Supervisor upon notice of the incident/injury from the employee.
2. **INJURED/INCIDENT WORKER REPORT** – completed by the injured Employee.
3. **WITNESS STATEMENT** – completed by each Witness of the accident or incident.

Supervisor – Check all forms for missing information. Have Employee or Witness fill in all areas required for reporting to Workers Compensation.

FAX TO Human Resources at 413-735-2209 within 24-hours.

- If the Employee requires non-emergency medical attention, the Supervisor must complete and sign a **"REQUEST FOR MEDICAL SERVICES"** form and a **"TEMPORARY PRESCRIPTION ID CARD."**
- **Provide both of these forms to the injured Employee. The Employee will provide the forms to the Medical Facility.**

SUPERVISOR INTAKE FORM OF STAFF INJURY/INCIDENT

TO BE RECEIVED AT LPVEC MAIN OFFICE WITHIN 24 HOURS OF ACCIDENT/INJURY

SUPERVISORS TO COMPLETE: Date of Report: _____

Injured Staff Name: _____ Date of Incident: _____

LPVEC Program: _____ Time of Incident: _____ a.m./p.m.

Program Location: _____ Injured Staff Occupation: _____

Address where incident occurred: _____

Describe the incident/accident. What was the employee doing? What happened? Why?

_____

_____

_____

What was the cause or unsafe act or condition and object or substance causing injury?

_____

Was employee wearing safety gear, if applicable? YES ☐ NO ☐ If yes, explain:

_____

What action was taken to prevent similar accidents?

_____

Injured Body Parts (please indicate right or left where applicable): _____

Type of Injury (Burn, Fracture, Cut, etc.): _____

To whom was Injury Reported? _____ Their Position? _____

Did Employee Lose Time From Work? YES ☐ NO ☐ If yes, give date(s) and number of hours: _____

Was medical treatment sought? YES ☐ NO ☐ If yes, where: _____

Was this incident witnessed? YES ☐ NO ☐

Name(s) of Witness(es)* (Print): _____

***EACH WITNESS MUST COMPLETE A WITNESS STATEMENT**

What action occurred following the injury or illness? ( ) Returned to Work ( ) Sent Home ( ) Sent for Treatment

Supervisor Name (Print): _____

Supervisor Signature: _____

INJURED/INCIDENT WORKER REPORT

TO BE RECEIVED AT LPVEC MAIN OFFICE WITHIN 24 HOURS OF ACCIDENT/INJURY

Name (Print): _____

Home Address: _____

Telephone Number(s): _____

Marital Status: _____ # of Dependents: _____

Height: _____ Weight: _____ Smoker: Yes No If yes, # packs per day _____

Date of Incident: _____ Time of Incident: _____ a.m. / p.m.

Address where incident occurred: _____

Describe what happened: _____

_____

_____

Injured Body Parts (please indicate right or left where applicable): _____

To whom was Injury Reported? _____ Their Position? _____

Name(s) of Witness(es)* (Print): _____

_____

Medical Authorization:

In accordance with the State Law, I, the undersigned, authorize A.I.M. Mutual Insurance Company, as a Workers' Compensation insurer and its authorized agents or representative, as well as my employer, to be furnished with any information or facts regarding this injury only, including records, diagnosis, medical treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the sole purpose of evaluating and handling my claim and to assure timely medial care because of the incident occurring on or about the above-noted date and for no other purpose, now or in the future. I also agree that a photocopy of this release is as valid as the original.

Employee Signature: _____ Date: ____/____/____

(CHECK OFF THE BOX BELOW ONLY IF YOU ARE NOT SEEKING TREATMENT AT THE TIME OF INJURY)

( ) I do not want medical treatment for this injury.

Employee Signature: _____ Date: ____/____/____

WITNESS STATEMENT

TO BE RECEIVED AT LPVEC MAIN OFFICE WITHIN 24 HOURS OF ACCIDENT/INJURY

Witness Name (Print): _____

Witness Home Address: _____

Witness Telephone Number(s): _____

Injured Staff Name: _____

Date of Incident: _____ Time of Incident: _____ a.m./p.m.

Address where incident occurred: _____

Describe what happened: _____

_____

_____

Injured Body Parts (please indicate right or left where applicable): _____

Signature of Witness: _____ Date: _____

A.I.M. Mutual
INSURANCE COMPANIES

A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

REQUEST FOR MEDICAL SERVICES

Date _____

Medical Care Provider: _____

Address:

_____

City _____ State _____ Zip _____

Kindly care for the injury sustained by:

_____ on: _____
(Name of Employee) *(Date)*

Description of accident: _____

_____

_____

Name of Employer: Lower Pioneer Valley Educational Collaborative

Address: 174 Brush Hill Avenue, West Springfield, MA 01089

Telephone: 413-735-2200 W.C. Policy Number: WMZ-800-8005496-2015A

Requested by: _____
(Signature)

The employee will present this slip to the medical care provider who will attach it to the original bill for services.

PLEASE SEND BILLS DIRECTLY TO:
A.I.M. Mutual Insurance Companies
c/o Corvel Corporation
P.O. Box 3040
Acton, MA 01720

MEDICAL BENEFITS ARE GOVERNED BY THE PROVISIONS OF THE WORKERS COMPENSATION LAW OF THE COMMONWEALTH OF MASSACHUSETTS.
AIM 20

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury
(enter in PA field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: AIM WORKS

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

Lower Pioneer Valley Educational Collaborative (LPVEC)

A.I.M. Mutual
INSURANCE COMPANIES

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale
Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School
Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast
Pharmacy Services
Osco
P & C Food
Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology
Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United
Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

EXPRESS SCRIPTS®